Health Insurance Plan
Detailed Summary

Benefit	**Insure Montana Standard and Premium Plan**	**State Employee Plan BCBS**	**Allegiance**	**SEIU 775 Health Benefits Trust Plan D underwritten by Premera Blue Cross IN-NETWORK BENEFITS**	**SEIU 775 Health Benefits Trust Plan B underwritten by Premera Blue Cross IN-NETWORK BENEFITS**
Professional Provided Services	Deductible waived for participating providers. Covered services include home and office calls, x-ray, lab, and other services provided by a Professional Participating Provider (PPP).	Office visits 75% (no deductible for first two non-routine visits) Inpatient physician services 75% Lab/ancillary/injectibles/ misc. charges 75% Preventive adult exams and tests 75% (no deductible) Adult immunization (such at Pneumonia and Flu) $50 max (no deductible), Allergy shots $50 max (no deductible)	Deductible and benefit percentage apply. $750 deductible and 70% benefit percent.	Office visits covered at 80% after $15 copay Inpatient physician services 80% Lab/ancillary/injectibles/misc. charges 80% Preventive adult exams covered in full and deductible waived Preventive tests (ie Mammography) 80% and deductible waived Adult immunization covered in full Allergy shots 80% after $15 office visit copay	Office visits covered at 90% after $10 copay Inpatient physician services 100% Lab/ancillary/injectibles/misc. charges 90% Preventive adult exams covered in full and deductible waived Preventive tests (ie Mammography) 90% and deductible waived Adult immunization covered in full Allergy shots 90% after $10 office visit copay
Emergency Services		Ambulance for medical emergency 75% Emergency room 65-80%		Ambulance $50 copay Emergency room $75 copay, then 80%	Ambulance $50 copay Emergency room $75 copay, then 90%
Inpatient Hospital	Room and board, special care units, ancillary charges and transplant coverage	Room charge, ancillary services, surgical services 65-80% Routine newborn care inpatient hospital charges 65-80% (no deductible)	Hospital room and board average semi-private Intensive care unit maximum eligible expense allowed.	$100 copay per day for the first 5 days per admission; no more than $2,000 copays to paid per calendar year	$100 copay per day for the first 5 days per admission; no more than $2,000 copays to paid per calendar year

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Outpatient Hospital	Accidental injury, x-ray, and lab, surgery, chemotherapy, respiratory therapy, radiation therapy, medical emergency, surgicenter, and other services	Hospital outpatient and surgical centers 65-80%		Hospital outpatient facility and professional services 80% after $15 office visit copay Surgical centers $100 copay	Hospital outpatient facility and professional services 90% after $10 office visit copay Surgical centers $100 copay
Urgent Care		Facility, professional charges and ancillary lab and diagnostic charges 75%.		Covered same as any other care	Covered same as any other care
Transplants	$10,000 for ambulance or air transport to site $25,000 for organ procurement per transplant $500,000 for maximum	75%, liver- $200,000, heart-$120,000, lung-$160,000, heart/lung-$160,000, bone marrow-$160,000, pancreas-$68,000, Cornea/kidney-no max	Max for each procedure: Liver- $170,000, heart-$145,000, kidney-$60,000, pancreas-$90,000, lung-$140,000, allogenic stem cell-$135-$215,000, other eligible-$50,000. Max aggregate lifetime $500,000.	No coverage available until covered under medical contract for 6 consecutive months, then covered as an other illness with a life time maximum of $250,000	No coverage available until covered under medical contract for 6 consecutive months, then covered as an other illness with a life time maximum of $250,000
Skilled Nursing	Skilled nursing facility, transitional care units and extended care facilities. Up to 60 days per benefit period (BP).	75% (65-80% if hospital-based) Max of 70 days/year		$100 copay per day for the first 5 days per admission; no more than $2,000 copays to paid per calendar year; limited to 60 days per calendar year	$100 copay per day for the first 5 days per admission; no more than $2,000 copays to paid per calendar year; limited to 60 days per calendar year

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Chiropractic Services	$400 maximum per BP. X-ray maximum is $100 per BP	75% (plus charges over $30/visit)	Max limit of 35 treatments per year, max benefit $25, max for diagnostic x-ray $100	$15 copay per visit limited to 12 visits per calendar year	$10 copay per visit limited to 12 visits per calendar year
Home Health Care	Up to 180 visits per BP, paid at 50%, deductible waived	75%, max of 70 days/year	Max visits per day 2, max allowance per visit $50, max per year $10,000, max per lifetime $20,000	80% limited to 130 visits per calendar year	90% limited to 130 visits per calendar year
Hospice	Paid at 100%, deductible and coinsurance waived	75% (65-80% if hospital-based), max of 6 months	Max per year $10,000, max per lifetime $20,000.	80% limited to 10 days per calendar year; respite care up to 240 hours per calendar year	$100 copay per day for the first 5 days for each admission. Coverage limited to 10 days per calendar year; respite care up to 240 hours per calendar year
Rehabilitation Therapy	Physical, occupational, speech, and cardiac rehabilitation therapies. $2,000 max per BP. Deductible is waived for PPP services. $100,000 lifetime max for in-patient and out-patient. Deductible waived for PPP services.	PT, OT, Cardiac, Pulmonary, and Speech included. Inpatient services 65-80% for a max of 60 days/year. Outpatient services 65-80% for a max $2,000/year for all outpatient	Max combined lifetime benefit $100,000. Physical, Occupation and Speech each have a max benefit per yea of $5,000.	Physical , Occupational, Speech and Massage therapy; cardiac & pulmonary rehab.; and chronic pain – covered same as any other service and limited up to 45 visits per calendar year	Physical , Occupational, Speech and Massage therapy; cardiac & pulmonary rehab.; and chronic pain – covered same as any other service and limited up to 45 visits per calendar year

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Durable Medical Equipment And Prostheses	Initial purchase, replacements and repair.	75% with max $100 for foot orthotics (per foot)	Max per year $15,000, max per lifetime $30,000	80% and generally limited to $5,000 per calendar year, depending on equipment	90% and generally limited to $5,000 per calendar year, depending on equipment
Severe Mental Health	Severe MI is processed under regular medical benefits		Paid the same as regular medical benefits		
Outpatient MH	Processed under regular medical benefits	65-80% with max 21 days (no max for severe condition)	Max number of visits per year 15, max benefit after deductible will not be less than $2,000	Covered same as any other services limited to 14 visits per calendar year	Covered same as any other services limited to 14 visits per calendar year
Inpatient MH	21 days for professional, hospital and/or freestanding inpatient facility charges, per member, per year.	With EAP counselor referral 75% with max 40 visits/year. Without EAP counselor referral 50% with max 20/visits year.	Max benefit per year 21 days.	Covered same as any other services limited to 10 days per calendar year	Covered same as any other services limited to 10 days per calendar year
Chemical Dependency	$6,000 per 12 months for inpatient and outpatient services. $12,000 lifetime maximum for inpatient services $2,000 inpatient and outpatient benefit available per benefit year after the $12,000 max is met	Inpatient service 65-80%, outpatient with EAP counselor referral 75% and 40 visit limit, outpatient with no EAP counselor referral 50% and 20 visit limit. Max combined inpatient and outpatient is $6,000/year; $12,00 lifetime; $2,000/year after maxmet	Max lifetime benefit $12,000, max benefit per 12 consecutive-month period $6,000, annual benefit after max benefit per lifetime is met $2,000.	Covered same as any other service and limited to $12,500 per 24 months	Covered same as any other service and limited to $12,500 per 24 months

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Well-Child Care	Exams (at 1, 2, 4, 6, 9, 15, 18 and 24 months) lab tests and routine immunizations from birth through 7. Deductible does not apply. Paid at 60% of the allowable fee.	75% (no deductible) and 0% (no deductible) for County health Dept. through age 7.	Routine outpatient well-child care birth -7 years deductible waived and paid at 100%. Max visit through 2 years of age 12. Visits age 3-7 is 1 per year.	$15 copay deductible waived for routine and preventive services performed on an outpatient basis, including immunizations	$10 copay deductible waived for routine and preventive services performed on an outpatient basis, including immunizations
Mammograms	Paid at the actual charge or $70, whichever is less, for each covered mammogram. Deductible and coinsurance apply after the first $70 is paid.	75% (no deductible)	Deductible waived and paid at 100%. Max benefit per mammogram is $70.	80% deductible waived	90% deductible waived
Diabetic Education Benefit	Up to $250 per benefit period for outpatient services. Deductible does not apply.	65-80% with max $250 per year	Max benefit per year $250.	Covered in full	Covered in full
Vision		$10 copay per eye exam, $125 allowance with 20% discount over $125 for frames, $20 copay standard lenses, $125 allowance contact lenses		$15 copay per exam once per calendar year; $130 towards vision hardware once per calendar year	$10 copay per exam once per calendar year; $130 towards vision hardware once per calendar year

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Prescription Drugs	$200 deductible per family member, then: Retail purchase 34-day supply: $10 generic, $30 formulary, $75 brand name, Mail-order purchase 90-day supply: $20 generic, $60 formulary, $150 brand name	Retail purchase 30-day supply: generic 10% coinsurance ($10 minimum), formulary 20% coinsurance ($25 minimum), brand name 40% coinsurance ($40 minimum). Mail-order purchase 90-day: generic $20 copay + 10% of cost over $400, formulary $20 copay + 20% of cost over $400, brand name $60 copay + 40% of cost over $400		Deductible waived $5 copay generic $20 copay preferred brand name $45 copay non-preferred brand name Mail order: 2 x the copay for a 90 day supply	Deductible waived $5 copay generic $15 copay preferred brand name $30 copay non-preferred brand name Mail order: 2 x the copay for a 90 day supply
Dental Plan	Preventive and diagnostic 100% Fillings/oral surgery 80% up to max of $1,000	Preventive and Diagnostic 100% Fillings, oral surgery, etc. 80% Dentures, Bridges, etc. 50 % Max yearly benefit for B and C of $1,200		$50 deductible 100% for Preventive and Diagnostic; 80% for Basic Services; 50% for Major services up to a maximum yearly benefit of $1,000	$50 deductible 100% for Preventive and Diagnostic; 80% for Basic Services; 50% for Major services up to a maximum yearly benefit of $1,000